UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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In Re: New York City Policing During Summer 2020 Demonstrations.

20 Civ. 8924 (CM)(GWG)
20 Civ. 10291(CM)(GWG)
20 Civ. 10541(CM)(GWG)
21 Civ. 322(CM)(GWG)
21 Civ. 533(CM)(GWG)
21 Civ. 1904(CM)(GWG)

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Pursuant to Rules 26, 33, and 34 of the Federal Rules of Civil Procedure and Local Rule 26.3 of this Court, defendants City, Mayor Bill de Blasio, Commissioner Dermot Shea and Chief of Department Terence Monahan hereby request that each plaintiff serve upon the undersigned sworn written answers to each of the interrogatories set forth below and produce for inspection and copying the documents requested below at the offices of Georgia M. Pestana, Acting Corporation Counsel of the City of New York at 100 Church Street, New York, New York 10007, within thirty (30) days after service hereof.

These interrogatories and document requests are continuing. If at any time after service of answers hereto, and prior to the trial of this action, plaintiffs obtain or become aware of additional information pertaining to any of these interrogatories or document requests, the disclosure of which may be required pursuant to Rule 26(e) of the Federal Rules, plaintiffs shall, within seven days, and in no event later than seven days before trial, serve upon the undersigned supplemental sworn written answers setting forth such additional information and documents.

INSTRUCTIONS

1. If the answer to all or any part of an interrogatory is not presently known or available, include a statement to that effect and furnish any information currently known or available and a description of the source of information that was once known or available that could have been used to respond to the interrogatory.

2. If any information or document called for by an interrogatory or document request is withheld by reason of a claim of privilege, state with specificity the information required by Local Rule 26.2.

DEFINITIONS

1. These definitions incorporate by reference the Uniform Definitions in Discovery Requests set forth in Federal Rule 34(a) and Local Rule 26.3.

2. As used herein, the term "Incidents" refers to the events described in the complaints.

INTERROGATORIES

1. Identify all persons who witnessed, were present at, or have knowledge of the Incidents, including the home and business addresses and telephone numbers of each witness. If you are unable to identify any of the individuals within the meaning of Local Rule 26.3, describe that individual's physical appearance.

2. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by plaintiffs or any other person that relate to the claims and/or subject matter of this litigation.

3. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by the City of New York, or its agents, servants and/or employees, that relate to the claims and/or subject matter of this litigation.

4. Identify all injuries claimed by plaintiffs as a result of the Incidents and the medical, psychiatric, psychological, and other treatment provided, if any. For each such

treatment received, identify the provider who rendered the treatment to plaintiffs. If no treatment was provided for any claimed injury, so state.

5. Identify all economic injuries claimed by plaintiffs as a result of the Incidents including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorneys fees. Identify the specific amounts claimed for each injury.

6. Identify all of plaintiffs' employers for the past ten (10) years, including the name, telephone number and address of each employer and the dates of each employment.

7. Identify all medical providers including, but not limited to, doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services, who have rendered treatment to the plaintiffs within the past ten (10) years.

8. Have plaintiffs applied for worker's compensation within the past ten (10) years? If so, identify each employer who provided worker's compensation to plaintiffs.

9. Have plaintiffs applied for social security disability benefits within the past ten (10) years? If so, identify each state, city, or other jurisdiction that provided social security disability benefits to plaintiffs.

10. Have plaintiffs applied for Medicare and/or Medicaid within the past ten (10) years? If so, identify each state, city or other jurisdiction that provided Medicare and/or Medicaid to plaintiffs.

11. Have plaintiffs made a claim with any insurance carrier for physical, mental or emotional injuries within the past ten (10) years? If so, identify each claim by date, injury and insurance carrier.

12. Identify all government agencies to whom plaintiffs made complaints regarding the Incidents including, but not limited to, the Civilian Complaint Review Board ("CCRB") and the Internal Affairs Bureau ("IAB") of the New York City Police Department, the New York State Office of the Attorney General, and the New York City Department of

Investigation, and further specify which plaintiff complained to which agency, as well as the nature and substance of each complaint.

13. Identify each occasion on which plaintiffs have been arrested other than the Incidents that is the subject of these lawsuits, including the dates of the arrests, the charges for which the plaintiffs were arrested, and the amount of time that plaintiffs spent incarcerated.

14. Identify each occasion in which plaintiffs have been convicted of a felony or misdemeanor, including the date of the convictions, the charges of which plaintiffs were convicted, and amount of time that plaintiffs spent incarcerated as a result of each conviction.

15. Identify each lawsuit to which plaintiffs have been a party, including the court in which the matter was pending, the docket or index number, and the disposition of the matter.

16. Identify each occasion on which plaintiffs have given testimony or statements regarding the subject of this lawsuit, including, but not limited to, the Civilian Complaint Review Board ("CCRB") and the Internal Affairs Bureau ("IAB") of the New York City Police Department, the New York State Office of the Attorney General, and the New York City Department of Investigation, and further specify which plaintiff gave testimony or statements to which agency, as well as the nature and substance of the testimony or statement.

17. Identify all treating physicians and other medical providers that plaintiffs intend to call at the time of trial.

18. Identify all experts that plaintiffs expect to call at the time of trial, all correspondence between counsels for plaintiffs and any such experts, any notes taken by any such experts and provide all disclosures required pursuant to Federal Rule 26(a)(2).

19. Identify all documents prepared by plaintiffs, or any other person, that relate to the Incidents, claims and subject matter of this litigation.

20. Identify all Freedom of Information Law requests and any responses thereto, made by plaintiffs or by anyone on plaintiffs' behalf, concerning plaintiffs' claims in this litigation.

21. Without regard to those accounts' privacy settings, identify all online accounts, including social media accounts, plaintiffs have used to post materials online in the past ten (10) years. This request includes, but is not limited to Facebook, Twitter, Instagram, Snapchat, TikTok, Pinterest, YouTube, Google+, LinkedIn, MySpace, or email services. As used in this Interrogatory, "Identify" means provide the username, account name, profile name, handle, or other unique identifier sufficient that said account can be located. If any account identified in response to this Interrogatory has been deactivated or deleted, state the date of such deactivation or deletion, and whether a copy of the content of that account exists in any form.

22. Identify all protests, marches, demonstrations and meetings attended by plaintiffs and/or proposed class members from 5/28/2020 until the present.

23. Identify any and all documents, information, statistical data, statements, or communications which support Plaintiffs' belief that a class is appropriate, including but not limited to any and all analyses, calculations, worksheets, and/or spreadsheets that allegedly support the statistics cited in the complaint.

DOCUMENT REQUESTS

1. Produce all the documents identified in the preceding Interrogatories.

2. Produce all the documents identified in Initial Disclosures to the extent they have not been produced.

3. Produce all documents regarding the Incidents, including documents concerning plaintiffs' arrests and criminal prosecution (if any), the minutes of any Grand Jury proceedings and criminal court transcripts, and any and all other documents concerning the Incidents that are in plaintiffs' possession, custody or control.

4. Produce all medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers, and other counseling services, in plaintiffs' possession, custody, or control for treatment received by plaintiffs since the Incidents and for the five years prior to the Incidents, including treatment for any injury resulting from the Incidents.

5. Produce all photographs, video, and other audio-visual materials documenting the Incidents, the scene of the Incidents, and all injuries that resulted from the Incidents, including injuries to person and property. Defendants request exact duplicates of the original photographs and audio-visual materials.

6. Produce all documentation of damages that plaintiffs allege stem from the Incidents, including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorneys fees. Documentation includes, but is not limited to, paid and unpaid bills, original purchase receipts, cancelled checks, charge slips, appraisals, and warranties.

7. Produce copies of all subpoenas served on any party, or any individual or entity, concerning this litigation.

8. Produce all documents received in response to any subpoenas served.

9. Produce all documents that relate to all complaints made by plaintiff to any government agency regarding the Incidents including, but not limited to, the CCRB and IAB of the New York City Police Department, the New York State Office of the Attorney General, and the New York City Department of Investigation.

10. If the plaintiffs are claiming lost income in this action, produce plaintiffs' federal and state income tax returns since the Incidents and for the five years prior to the Incidents.

11. Produce: (a) all expert disclosures required pursuant to Federal Rule 26(a)(2); (b) any drafts of any reports or other disclosures required by Fed. R. Civ. P. 26(a)(2);

(c) all correspondence between plaintiffs' counsels, or anyone acting for or on behalf of plaintiffs or plaintiffs' counsels, and any experts identified in response to Interrogatory No. 18, including, but not limited to, any documents reflecting any fee agreements and any instructions plaintiffs' counsels have provided to the expert regarding the expert's expected testimony and/or examination of plaintiffs; and (d) any notes taken by any experts identified in response to Interrogatory No. 18 regarding plaintiffs, plaintiffs' counsels, the Incidents alleged in the complaint, this lawsuit, the expert's expected testimony or the expert's retention by plaintiffs' counsels in this action.

12. Complete and provide the annexed blank authorizations for release of plaintiffs' medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services for treatment received by plaintiffs since the Incidents and for the five years prior to the Incidents, including treatment for any injury resulting from the Incidents.[1]

13. Complete and provide the annexed blank authorization for access to plaintiffs' records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55. Note that the authorization for access to plaintiffs' records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55 that is annexed hereto differs from the authorization that may have been provided at the outset of this litigation in that it is not limited to documents pertaining to the arrest and/or prosecution that is the subject of this litigation.

14. Complete and provide the annexed blank authorizations for release of employment records for each of plaintiffs' employers for the past ten (10) years.[2]

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[1] The enclosed releases are believed to be HIPAA-compliant. Please note that HHC hospitals require a particular release, a copy of which is enclosed. A separate release must be provided for each provider. Kindly photocopy the releases before execution so plaintiff can provide a separate release for each provider. The attached release for psychotherapy notes must be provided in addition to a HIPAA release for that provider.

[2] A separate release must be provided for each of plaintiff's employers. A single release form is enclosed. Kindly photocopy the release before execution so plaintiff can provide a separate release for each employer.

15. Complete and provide the annexed blank authorization for the unemployment records, if any, of plaintiffs.

16. Complete and provide the annexed blank authorizations for insurance carriers with whom plaintiffs have made claims within the past ten (10) years.[3]

17. Complete and provide the annexed blank authorization for the records of social security disability benefits, if any, received by plaintiffs.[4]

18. Complete and provide the annexed blank authorization for plaintiffs' Medicare and/or Medicaid records.[5]

19. Produce any and all statement(s) issued or made by plaintiffs concerning the Incidents to any of member of a press outlet or similar institution, including but not limited to newspapers, television or radio broadcasts, any online publications, including podcasts or blogs, or any independent media outlet in any format..

20. Produce copies of all posts, messages, videos, or other content concerning the Incidents made by plaintiffs to any of the online accounts identified in Interrogatory No. 21, above, or posted as comments to any other individual's or entity's social media account, or as comments to any online publication or blog.

21. Produce copies of all posts, messages, videos, or other content concerning the Incidents that were posted or sent by any individual to any of the online accounts identified in Interrogatory No. 21, above.

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[3] A separate release must be provided for each insurance carrier. A single release form is enclosed. Kindly photocopy the release before execution so plaintiff can provide a separate release for each insurance carrier.

[4] A separate release must be provided for each jurisdiction. Kindly photocopy the release before execution so plaintiff can provide a separate release for each such jurisdiction.

[5] A separate release must be provided for each jurisdiction. Kindly photocopy the release before execution so plaintiff can provide a separate release for each such jurisdiction.

22. Produce copies of all materials provided to you by any City of New York department or entity, or any individual or entity not associated with the City of New York to assist in investigating the Incidents.

23. Produce copies of all reports of any investigations conducted into the Incidents, including, but not limited to, all notes and draft reports.

24. Produce all documents or any other information which support plaintiffs belief that a class is appropriate.

25. Produce all documents or any other information identifying the members of the potential class.

26. Produce all documents or any other information identifying that the claims or defenses of the representative class parties, i.e. Plaintiffs, are typical of the claims or defenses of the class.

27. Produce all photographs and other audio-visual materials taken or recorded by plaintiffs documenting any protests in New York City before, during and after the Incident. Defendants request exact duplicates of the original photographs and audio-visual materials.

Dated: New York, New York
March 25, 2021

GEORGIA PESTANA
Acting Corporation Counsel of the
City of New York
Attorney for Defendants City, de Blasio, Shea, Monahan
100 Church Street
New York, New York 10007

By: Dara L. Weiss
Dara L. Weiss
Senior Counsel

TO: **By Electronic Mail**
Counsel for all Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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In Re: New York City Policing During Summer 2020 Demonstrations.

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

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TO: _____
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of _____ health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of _____ (Date of Birth:_____; SS #:_____) who was examined or treated in your hospital or by you on or about_____.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
_____, 2021

_____

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2021, before me personally came and appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested_____ Treatment Dates from_____ to_____
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.** ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☐ Legal Matter ☐ Individual's Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ On this date:_____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if l place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9. (a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/Firm Name or Government Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

xRELEASE FOR
PSYCHOTHERAPY NOTES

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In Re: New York City Policing During Summer 2020 Demonstrations.

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TO: _____ [Health Care Provider]
_____ [Address]
_____ [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of _____(Date of Birth: _____; SS #: _____) who was examined or treated in your hospital or by you on or about _____. The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to Georgia Pestana, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
_____, 2021

_____

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2021, before me personally came and appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

DESIGNATION OF AGENT FOR ACCESS TO RECORDS SEALED PURSUANT TO NYCPL §§ 160.50 AND 160.55

I, _____, Date of Birth _____, SS# _____, NYSID # _____ pursuant to CPL §§ 160.50 and 160.55, hereby designate GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom all records of any of my arrests may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to any and all of my arrests on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

_____
Signature

_____

STATE OF NEW YORK)
: SS.:
COUNTY OF)

On the _____ day of _____, 2021, before me personally came _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and he acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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RELEASE FOR EMPLOYMENT RECORDS

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TO: _____
NAME AND ADDRESS OF EMPLOYER

YOU ARE HEREBY AUTHORIZED to furnish to GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire employment record, including but not limited to he application, attendance records, disciplinary records, performance evaluations, workers' compensation records, medical records/nurses records, and/or any doctors notes, and psychiatric/psychological records of _____ (Date of Birth:_____; SS #:_____), employed by you from _____ until _____.

Dated: New York, New York
_____, 2021

_____

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2021, before me personally came and appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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UNEMPLOYMENT RECORDS RELEASE

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TO: DEPARTMENT OF LABOR

YOU ARE HEREBY AUTHORIZED to furnish to GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of _____ (Date of Birth:_____; SS #:_____), who received unemployment benefits from _____ to _____.

The unemployment file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

The information is sought for the purpose of _____ and will be used solely for this purpose.

Dated: New York, New York
_____, 2021

_____

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2021, before me personally came and appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

_____ _____ _____
* Name * Date of Birth * Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME** ***ADDRESS**

_____ _____

_____ _____

_____ _____

*I want this information released because: _____

_____

_____

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) _____

_____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date _____

Relationship *(If no the individual)*: _____ *Daytime Phone: _____

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. if you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be changed.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a requires field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the patent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is required, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request to SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests to SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Officer of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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In Re: New York City Policing During Summer 2020 Demonstrations.

20 Civ. 8924 (CM)(GWG)
20 Civ. 10291(CM)(GWG)
20 Civ. 10541(CM)(GWG)
21 Civ. 322(CM)(GWG)
21 Civ. 533(CM)(GWG)
21 Civ. 1904(CM)(GWG)

MEDICARE RECORDS RELEASE

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TO: FOIA Service Center/FOIA Public Liaison
Centers for Medicare Services
26 Federal Plaza
New York, NY 10278

YOU ARE HEREBY AUTHORIZED and I hereby request you to furnish to GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of _____ (Date of Birth:_____; SS #:_____), who received Medicare benefits from _____ to _____.

The Medicare file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

The reason for this release of information is (a) at the request of individual, or (b) _____.

This Authorization will expire at the conclusion of the above-captioned litigation.

I understand that I have the right to revoke this authorization at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorization to. The revocation will not apply to information that has already been released in response to this authorization.

I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law.

Dated: New York, New York
_____, 2021

_____

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2021, before me personally came and appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
AUTHORIZATION TO RELEASE PROTECTED MEDICAID MEMBER INFORMATION TO A THIRD PARTY

Medicaid Member Name (required): _____

Date of Birth (required): _____/_____/_____

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): _____ Social Security Number (SSN): _____-_____-_____

_____

Persons/organizations authorized to receive or use the information:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Dates authorized: ☐ All OR From _____/_____/_____ To _____/_____/_____ OR ☐ To Present

Purpose of the use/disclosure: _____

Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

1. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for the health plan's eligibility or enrollment determinations relating to the individual.

2. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

3. I may revoke this authorization at any time by notifying the Department of Health in writing at the address below, but, if I do, it will not have any effect on actions that the Department took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request or one year from the date this form is signed, whichever comes first.

4. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, and therefore the recipient of the confidential data may re-disclose the confidential data.

By signing this form I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medical Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specially authorize release of such information to the person(s) indicated above as the recipient.

_____

_____ _____
Signature of Medicaid member of Agent Date

_____ _____
If not member, name of person signing for member Authority to sign on behalf of member

_____ _____
Witness Signature Witness Name

Please return to:
Medical Data Warehouse - CDRs
NYSDOH - MISCNY
ESP P1-11S Dock J
Albany, New York 12237

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

14. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if l place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

15. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

16. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

17. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

18. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

19. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

20. Name and address of health provider or entity to release this information:
NYC HUMAN RESOURCES ADMINISTRATION, DEPT. OF SOCIAL SERVICES

21. Name and address of person(s) or category of person to whom this information will be sent:

22. (a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: **Medicaid Records**

_____

Include: *(Indicate by Initialing)*
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____
Initials Name of individual health care provider
to discuss my health information with my attorney, or a government agency, listed here:

_____
(Attorney/Firm Name or Government Agency Name)

23. Reason for release of information:
☐ At request of individual
☐ Other:

24. Date or event on which this authorization will expire:

25. If not the patient, name of person signing form:

26. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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In Re: New York City Policing During Summer 2020 Demonstrations.

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20 Civ. 10291(CM)(GWG)
20 Civ. 10541(CM)(GWG)
21 Civ. 322(CM)(GWG)
21 Civ. 533(CM)(GWG)
21 Civ. 1904(CM)(GWG)

RELEASE FOR INSURANCE CARRIER RECORDS

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TO: _____
NAME AND ADDRESS OF INSURANCE CARRIER

YOU ARE HEREBY AUTHORIZED to furnish to GEORGIA PESTANA, Acting Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of _____ (Date of Birth:_____; SS #:_____), who received benefits from your insurance company.

The insurance carrier file authorized for release includes, but is not limited to, any and all applications, description of injuries, determinations, correspondence, payments or credits and all documents relating to such person's claim for insurance benefits.

Dated: New York, New York
_____, 2021

_____

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2021, before me personally came and appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC